Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Public Report

Report Issue Date: December 24, 2024
Inspection Number: 2024-1500-0004
Inspection Type: Critical Incident
Licensee: Nisbet Lodge
Long Term Care Home and City: Nisbet Lodge, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 20, 2024
The inspection occurred offsite on the following date(s): December 23, 2024

The following intake(s) were inspected:

- Intake: #00134847 related to a disease outbreak.

The following intake was completed:

- Intake: #0012738 related to a disease outbreak.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

(A) In accordance with Additional Requirement 7.3 (b) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure that the IPAC Lead conducted quarterly audits to ensure that the Dietary and Program staff could perform the IPAC skills required of their role.

Sources: IPAC practice audits; and interviews with the IPAC Lead and Director of Care (DOC). [665]

(B) In accordance with Additional Requirement 10.4 (d) under the IPAC Standard, the licensee has failed to ensure that monthly hand hygiene audits were conducted for the Dietary, Program and Environmental staff.

Sources: IPAC practice audits; and interviews with the IPAC Lead and DOC. [665]

(C) In accordance with Additional Requirement 4.3 under the IPAC Standard, the licensee has failed to ensure that following the resolution of an outbreak, the outbreak management team (OMT) and the interdisciplinary IPAC team created a summary of findings that made recommendations to the licensee for improvements to outbreak management practices. The DOC acknowledged that the summary was not created following the resolution of their confirmed COVID-19 outbreak.

Sources: Review of a Critical Incident report; and interview with DOC. [665]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2).

The licensee has failed to ensure that on every shift, a resident's symptoms indicating the presence of infection were monitored.

A resident was on additional precautions and their symptoms of infection were not monitored every shift.

Sources: A resident's clinical records; and interviews with the IPAC Lead and DOC. [665]

WRITTEN NOTIFICATION: CMOH and MOH

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable guidance, advice or recommendations issued by the Chief Medical Officer of Health (CMOH) was complied with.

In accordance with the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective October 2024, alcohol based hand rub (ABHR) in use were not to be expired.

An ABHR at the entrance of a resident's room was expired.

Sources: ABHR Observation; and Ministry of Health's Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective October 2024. [665]